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Supplemental Instructions for TPL Exceptions

Submitting Claims for Members with Medicare or Commercial Insurance

This appendix contains supplemental billing instructions for submitting 837I transactions, direct data entry (DDE) claims for members who have Medicare or commercial insurance, and whose services are determined not covered by the primary insurer. This appendix describes TPL exceptions that may apply when members have Medicare or commercial insurance. This appendix contains specific MassHealth billing instructions and supplements the instructions found in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide.

MassHealth requires all claims to be submitted in an electronic format unless the provider has received an approved electronic claim submission waiver. See [All Provider Bulletin 217](#).

Third-Party Liability (TPL) Requirements

To ensure that MassHealth is the payer of last resort, generally providers must make diligent efforts to obtain payment from other resources before billing MassHealth. See MassHealth regulations at 130 CMR 450.316. Providers must submit a claim and seek a new coverage determination from the insurer any time a member's condition or health insurance coverage status changes, even if Medicare or a commercial insurer previously denied coverage for the same service.

Medicare Exceptions

Home-health services for a MassHealth member must be billed to Medicare unless one or more of the following exceptions exists.

- The member is not confined to place of residence.
- The member is not part-time or intermittent; death is imminent.
- The member is not part-time or intermittent; alternative is more costly.
- The member is not part-time or intermittent; alternative is being sought.
- The member is not part-time; physician documentation of medical necessity exceeds eight hours.
- The member is not intermittent; physician documentation of medical necessity exceeds 21 days.
- The member is receiving occupational therapy only.

Medicare

If one of these TPL exceptions exists above, follow the instructions outlined in this appendix for claim submission.

Providers must file a claim and seek a new coverage determination any time a member's medical condition or medical circumstance changes, even if Medicare previously denied coverage for the same service. Providers are required to retain the Medicare advance beneficiary notice (ABN) for auditing purposes.

Medicare Denials

If a claim for a MassHealth member has been submitted to Medicare and subsequently denied, providers must forward the Medicare remittance advice to MassHealth within 10 days of its receipt.

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Remittance advices must be sent to the following address.

UHealth Solutions, Inc.
Third-Party Appeals Unit
Medicare Appeals Unit
100 Century Drive
Worcester, MA 01606

Commercial Insurance

Home health services for a member with commercial insurance must generally be billed to the commercial insurer before submitting a claim to MassHealth. Refer to MassHealth regulations at 130 CMR 450.316.

Even if an insurer previously denied coverage for the same service, providers must submit a claim and seek a new coverage determination from an insurer whenever there is a new admission or a change in the member's medical condition or health insurance coverage status, known as a "qualifying event." A qualifying event is defined as any change in a member's condition or circumstance that may trigger a change in insurance coverage. The following list includes some examples of qualifying events that would require a coverage determination by a commercial insurer.

- new services from a home health agency (HHA);
- new HHA services after discharge from an inpatient hospital or skilled facility stay resulting in a change of skilled services in the plan of care;
- new commercial insurance coverage or change of insurer;
- commencement of annual commercial insurance coverage or other periodic benefit(s);
- reinstatement of insurance benefits; or
- change in the patient's medical condition resulting in a change of skilled services in the plan of care.

If after review, the commercial carrier has denied the claim due to noncoverage, providers should follow the HIPAA implementation guides and MassHealth companion guides for submission of the initial claim to MassHealth. Implementation and companion guides are available on the MassHealth website at www.mass.gov/masshealth.

Providers are required to keep on file for auditing purposes the insurer's original explanation of benefits (EOB), 835 transaction, or response from the insurer. Providers must continue to submit a copy of the insurer's denial accompanied by the [Home Health Coverage Determination Form](#) within 10 days of its receipt as instructed in [Home Health Agency Bulletin 46](#), dated January 2009. Both the form and the bulletin are available on the MassHealth website at www.mass.gov/masshealth.

TPL Exception Criteria

Claims for MassHealth members who have Medicare or commercial insurance must be initially billed to Medicare or the commercial insurer, or a Medicare ABN must be issued.

There may be instances when the services provided are not covered by the other insurer, including if the MassHealth member does not:

- have benefits available (benefits have been exhausted);
- meet the insurer's coverage criteria; or
- qualify for a new benefit period.

Follow the instructions outlined in this appendix for claim submissions when a TPL exception exists.

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Providers are required to keep the following items on file for auditing purposes.

- the Medicare ABN;
- the Medicare remittance advice; and
- the commercial insurer's original EOB, 835 transaction, or response from the insurer.

Billing Instructions for 837I Transactions

Providers must follow HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide instructions. Complete the other payer loops in the 837I transactions as described in the following table when submitting claims to MassHealth that have been determined not covered by the other insurer, and that meet the TPL exception criteria.

The table below contains the critical loops and segments required for submitting claims to MassHealth that have been determined to be not covered by the other insurer, and that meet the TPL exception criteria listed in this section. Providers must complete the loops and segments as described in the table below and follow instructions described in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide to complete other required COB and non-COB portions of the 837I claim submission.

The Total Noncovered Amount segment is used to indicate that the insurer has determined the service to be not covered. Do not report HIPAA adjustment reason codes and amounts in the 2320 loop containing the total noncovered amount.

Loop	Segment	Value
2320	SBR09 (Claim Filing Indicator)	Medicare = MA 837I: Commercial insurer = CI
2320	AMT01 (Total Noncovered Amount Qualifier)	A8
2320	AMT02 (Total Noncovered Amount)	The total noncovered amount must equal the total billed amount.
2330B	NM109 (Other Payer Name)	MassHealth-assigned carrier code for the other payer Please Note: MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual.

Billing Instructions for Direct Data Entry (DDE)

Providers must enter the COB information as described in the following table when submitting claims to MassHealth that have been determined to be not covered by the other insurer, and that meet the TPL exception criteria described in this section. Providers must follow instructions in the MassHealth billing guides to complete other required COB and non-COB data fields of the DDE claim submission that are not specified in the following table.

The Total Noncovered Amount field is used to indicate that the insurer has determined the service to be not covered. Do not enter HIPAA adjustment reason codes and amounts on the List of COB Reasons panel when reporting a total noncovered amount.

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On the Coordination of Benefits tab, click “New Item” and complete the fields as described below.

COB Detail Panel	
Field Name	Instructions
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. Please Note: MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual.
Carrier Name	Enter the appropriate carrier name. Refer to Appendix C of your MassHealth provider manual.
Remittance Date	Do not enter a remittance date.
Payer Claim Number	Enter 99.
Payer Responsibility	Select the appropriate code from the drop-down list.
COB Payer Paid Amount	Do not enter a COB payer paid amount.
Total Noncovered Amount	The total noncovered amount must equal the total billed amount.
Remaining Patient Liability	Do not enter any values.
Claim Filing Indicator	Medicare = MA Commercial insurer = CI
Release of Information	Select the appropriate code from the drop-down list.
Assignment of Benefits	Select the appropriate code from the drop-down list.
Relationship to Subscriber	Select the appropriate code from the drop-down list.

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COB Detail Panel (cont.)	
Field Name	Instructions
Subscriber Information Panel	<p>If you select "Relationship to Subscriber," and it is "18 –Self," then click "Populate Subscriber." The panel will fill the following data fields that have already been entered on the "Billing and Service" tab.</p> <ul style="list-style-type: none"> • Subscriber Last Name • Subscriber First Name • Subscriber Address • Subscriber City • Subscriber State • Subscriber Zip Code • If you select any other relationship-to-subscriber code, you must enter the following required fields. • Subscriber Last Name • Subscriber First Name
Subscriber ID	Enter the Other Insurance Subscriber ID number.

Please Note: Click "Add" to save the COB panel.

MassHealth's Right to Appeal

MassHealth reserves the right to appeal any case that, in its determination, may meet the coverage criteria of an insurance carrier. Providers must, at MassHealth's request, submit the claim and related clinical or service documentation to an insurance carrier if MassHealth determines that the provider's submission is necessary in order for MassHealth to exercise its right to appeal.

Questions

If you have any questions about the information in this appendix, please refer to [Appendix A](#) of your MassHealth provider manual for the appropriate contact information.

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